Letters to the Editor

The Journal welcomes letters to the editor. If found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with Journal style. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication. Send letters to Paul M. Fischer, Editor, The Journal of Family Practice, Department of Family Medicine, Medical College of Georgia, Augusta, GA 30912, or Fax (706) 855-1107.

PSYCHIATRY IN 2001

To the Editor:

Dr C. Knight Aldrich, in his article about the future role of psychiatry (*Aldrich CK. Psychiatry in 2001. J Fam Pract 1993; 36:323–8*), champions greater commitment to psychosocial training in family practice, observing with dismay the recent schism between psychiatry and clinical psychology, and the explosion of knowledge in the area of neuropsychiatry, and fearing a colder, less effective therapeutic milieu for patients. While agreeing with some of these concerns, several points require commentary.

Personality and mood cannot be easily divided into predominant spheres of influence. Mood is the dynamo that powers personality to produce behavior; thus, mood has a more central role in the process. Personality contains elements of temperament (inherited behavioral inclinations) and character (environmentally determined inclinations).

By relegating some behavioral pathology to the realm of biology and some to the realm of personality, one could easily fail to see that Mrs Sommers, Aldrich's fictional somatizing patient, *is* biologically ill, even if much of her behavior seems characterologic. Dysthymia, formerly depressive neurosis, is still considered by many physicians to be of character pathology, in spite of scientific evidence to the contrary. Dysthymia is more prevalent than "major" depression, and is associated with greater morbidity and mortality. Aldrich's limitation on medication ignores the reality that psychosocial disruptions are often secondary to illness, not primary.

Family physicians are perfectly placed in the health care system for some role in psychotherapy. Much of what is needed, however, is not formal training in psychotherapy, but a caring and supportive attitude coupled with the expectation that real change is possible.

This article was read just after arriving home from work, where my last patient encounter was a 1-hour consultation with the distraught mother of a depressed 19-year-old daughter. Predictably, they are embroiled in a struggle of control vs independence. Psychotherapy will certainly be needed for a full recovery. Additionally, and just as importantly, one could conclude from this interview that her biological father was bipolar, and she will not make a full recovery without medication.

Family physicians can be effective therapists, but it is not instruction in psychotherapy that is missing from our training programs. Missing is a truly integrated approach to the treatment of mental illness. Inherited vulnerability and limbic dysregulation are as important as psychosocial factors in treatment planning. In the lingo of the biopsychosocial, family physicians need more "bio," not less. We should take the best of both worlds and use it for our patient's good.

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The preceding letter was referred to Dr Aldrich, who responds as follows:

I thank Dr Manning for his comments, and I welcome the opportunity to clarify my position. First of all, it is not the explosion of knowledge in neuropsychiatry that I look upon with dismay; what dismays me is that psychiatrists, in their enthusiasm for the new discoveries, too often seem to be ignoring or forgetting the psychosocial.

Since neither the biological nor the psychosocial component should be ignored or forgotten, the psychologically troubled patient needs a therapist who understands and respects both components and who, therefore, can use either psychosocial or biological treatment, or both, depending on what seems best for that patient. When both treatment approaches are indicated, as I stated in my article, medications are used in combination with counseling.

The potential for understanding both components is a major advantage family physicians have over the nonmedical mental health professional in picking up the psychotherapeutic role that the field of psychiatry seems so bent on abdicating. Another advantage is family medicine's commitment, unparalleled in the rest of medicine, to the biopsychosocial concept.

If family physicians take up the psychotherapy option, instruction in psychotherapy will be needed because psychotherapy requires—or should require—a search for the specific causes of a condition. This search is required so that the psychosocial aspect of treatment can be planned and focused according to the patient's unique history and individual characteristics. Caring, providing emotional support, and faith in the human capacity for personal change are important for all physicians, but they are nonspecific measures that only go so far; knowing specifically why, when, and how to use which psychotherapeutic techniques can be as crucial to the troubled patient's future well-being as knowing why, when, and how to use any other medical intervention.

Thus, in Mrs Sommers's case, as our experience in Chicago and elsewhere with similar patients has demonstrated, appropriate attention to the specific psychosocial components of her chronic somatization illness, with adjunctive medication as indicated, is likely to improve her level of functioning more effectively and more efficiently than either medications alone or nonspecific caring and support alone.

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MYOCARDIAL INFARCTION

To the Editor:

The article by Green and Ruffin[1] on suspected myocardial infarction challenges us to revise our view of this disease. In their study, a man admitted for suspected myocardial infarction was 1.53 times more likely than a woman to be placed in an intensive care unit instead of a telemetry floor. Our study of patients with suspected myocardial infarction or unstable angina came up with remarkably similar results.[2] We found that men were 1.48 times more likely than women to be placed in the intensive care unit. In addition, time to initial evaluation by a physician was longer for women than men who presented with acute nontraumatic chest pain. Furthermore, women had to

wait longer for an initial 12-lead electrocardiogram.

Together, these studies make a strong point. We must improve our understanding of myocardial ischemia and guard against sex bias in its management.

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1. Green LAE, Ruffin MT. Differences in management of suspected myocardial infarction in men and women. J Fam Pract 1993; 36:389–93.
2. Heston TF, Lewis LM. Gender bias in the evaluation and management of acute nontraumatic chest pain. Fam Pract Res J 1992; 12:383–9.